

Medicare Personal Plan Finder

2005 Cost and Benefits Information

Contact Information:

State Health Insurance Assistance Program: 1-800-333-4114

State Health Insurance Department: 1-800-342-3736

Erie County Dept. of Senior Services HHCAP Program (716) 858-7883

Plan Name	Excellus Health Plan, Inc. Univera Medicare PPO 102 (H3335 - 002)	Excellus Health Plan, Inc. Univera Medicare PPO 103 (H3335 - 003)	Traditional Blue Medicare PPO Traditional Blue Medicare PPO 201 Plus (H3324 - 002)	Traditional Blue Medicare PPO Traditional Blue Medicare PPO 202 Plus (H3324 - 004)
Plan Service Area	Univera Healthcare	Western New York	Western New York	Western New York
Plan Type	Preferred Provider Organization	Preferred Provider Organization	Preferred Provider Organization	Preferred Provider Organization
Federal Approval Status	As submitted by organization	As submitted by organization	As submitted by organization	As submitted by organization
Tax Status	Non-Profit	Non-Profit	Non-Profit	Non-Profit
Plan Contact	* Customer Service For Prospective Members: 1-800-659-1986 1-800-421-1220 (TTY/TDD) For Current Members: 1-800-509-6350 1-800-421-1220 (TTY/TDD)	* Customer Service For Prospective Members: 1-800-659-1986 1-800-421-1220 (TTY/TDD) For Current Members: 1-800-509-6350 1-800-421-1220 (TTY/TDD)	Tom Gormley For Prospective Members: 1-800-248-9296 1-877-286-5710 (TTY/TDD) For Current Members: 1-800-329-2792 1-877-834-6918 (TTY/TDD)	Tom Gormley For Prospective Members: 1-800-248-9296 1-877-286-5710 (TTY/TDD) For Current Members: 1-800-329-2792 1-877-834-6918 (TTY/TDD)
Mailing Address	205 Park Club Lane Williamsville, NY 14221	205 Park Club Lane Williamsville, NY 14221	1901 Main Street Buffalo, NY 14208	1901 Main Street Buffalo, NY 14208
Web Site Address	www.excellus.com	www.excellus.com	www.bcbswny.com (WNY) or www.bsneny.com (NENY)	www.bcbswny.com (WNY) or www.bsneny.com (NENY)
Physician Network Information	There are approximately 3001-3500 physicians and providers in this plan's network. This	There are approximately 3001-3500 physicians and providers in this plan's network. This	There are approximately 2501-3000 physicians and providers in this plan's network. This	There are approximately 2501-3000 physicians and providers in this plan's network. This

	plan has a web site at www.excellus.com which lists physicians and providers that are part of their network. This site also lists physicians who are currently taking new patients.	plan has a web site at www.excellus.com which lists physicians and providers that are part of their network. This site also lists physicians who are currently taking new patients.	plan has a web site at www.bcbswny.com (Western New York) or www.bsneny.com (Northeastern New York) which lists physicians and providers that are part of their network.	plan has a web site at www.bcbswny.com (Western New York) or www.bsneny.com (Northeastern New York) which lists physicians and providers that are part of their network.
Important Notes			The benefits presented below, including premium and cost sharing, are subject to change pending Federal review.	The benefits presented below, including premium and cost sharing, are subject to change pending Federal review.
1 - Premium and Other Important Information	<p>You pay \$ 48 each month. You also continue to pay the Medicare Part B premium of \$78.20 each month. There is a \$ 2500 maximum out-of-pocket limit every year for the following plan services when received out of network only:</p> <ul style="list-style-type: none"> - Inpatient Hospital Care - Inpatient Mental Health Care - Skilled Nursing Facility - Home Health Care - Doctor Office Visits - Chiropractic Services - Podiatry Services - Outpatient Mental Health Care - Outpatient Substance Abuse Care - Outpatient Services/Surgery - Ambulance Services - Urgently Needed 	<p>You pay \$ 48 each month. You also continue to pay the Medicare Part B premium of \$78.20 each month. There is a \$ 2500 maximum out-of-pocket limit every year for the following plan services when received out of network only:</p> <ul style="list-style-type: none"> - Inpatient Hospital Care - Inpatient Mental Health Care - Skilled Nursing Facility - Home Health Care - Doctor Office Visits - Chiropractic Services - Podiatry Services - Outpatient Mental Health Care - Outpatient Substance Abuse Care - Outpatient Services/Surgery - Ambulance Services - Urgently Needed 	<p>You pay \$ 50 each month. You also continue to pay the Medicare Part B premium of \$78.20 each month. There is a \$ 2500 maximum out-of-pocket limit every year for the following plan services when received out of network only:</p> <ul style="list-style-type: none"> - Inpatient Hospital Care - Inpatient Mental Health Care - Skilled Nursing Facility - Home Health Care - Doctor Office Visits - Chiropractic Services - Podiatry Services - Outpatient Mental Health Care - Outpatient Substance Abuse Care - Outpatient Services/Surgery - Ambulance Services - Urgently Needed 	<p>You pay \$ 80 each month. You also continue to pay the Medicare Part B premium of \$78.20 each month. There is a \$ 2500 maximum out-of-pocket limit every year for the following plan services when received out of network only:</p> <ul style="list-style-type: none"> - Inpatient Hospital Care - Inpatient Mental Health Care - Skilled Nursing Facility - Home Health Care - Doctor Office Visits - Chiropractic Services - Podiatry Services - Outpatient Mental Health Care - Outpatient Substance Abuse Care - Outpatient Services/Surgery - Ambulance Services - Urgently Needed

	<p>Care</p> <ul style="list-style-type: none"> - Outpatient Rehabilitation Services - Durable Medical Equipment - Prosthetic Devices - Diabetes Self-Monitoring Training and Supplies - Diagnostic Tests, X-Rays, and Lab Services - Bone Mass Measurement - Colorectal Screening Exam - Immunizations - Mammograms (Annual Screenings) - Pap Smears and Pelvic Exams - Prostate Cancer Screening Exams - Outpatient Prescription Drugs - Hearing Services - Vision Services - Routine Physical Exams - CORF - Partial Hospitalization - Other Health Care Professional Services - Clinical/Diagnostic Lab Services - Radiation Therapy Services - Cardiac Rehabilitation Services - Renal Dialysis - Outpatient Blood <p>There is a \$ 2500 maximum out-of-pocket limit every year for the following plan services when received out of network only:</p> <ul style="list-style-type: none"> - Home Health Care - Doctor Office Visits 	<p>Care</p> <ul style="list-style-type: none"> - Outpatient Rehabilitation Services - Durable Medical Equipment - Prosthetic Devices - Diabetes Self-Monitoring Training and Supplies - Diagnostic Tests, X-Rays, and Lab Services - Bone Mass Measurement - Colorectal Screening Exam - Immunizations - Mammograms (Annual Screenings) - Pap Smears and Pelvic Exams - Prostate Cancer Screening Exams - Outpatient Prescription Drugs - Hearing Services - Vision Services - Routine Physical Exams - CORF - Partial Hospitalization - Other Health Care Professional Services - Clinical/Diagnostic Lab Services - Radiation Therapy Services - Cardiac Rehabilitation Services - Renal Dialysis - Outpatient Blood <p>There is a \$ 2500 maximum out-of-pocket limit every year for the following plan services when received out of network only:</p> <ul style="list-style-type: none"> - Home Health Care - Outpatient Mental Health Care 	<p>Care</p> <ul style="list-style-type: none"> - Outpatient Rehabilitation Services - Durable Medical Equipment - Prosthetic Devices - Diabetes Self-Monitoring Training and Supplies - Diagnostic Tests, X-Rays, and Lab Services - Bone Mass Measurement - Colorectal Screening Exam - Immunizations - Mammograms (Annual Screenings) - Pap Smears and Pelvic Exams - Prostate Cancer Screening Exams - Hearing Services - Vision Services - Routine Physical Exams - Health/Wellness Education - Transportation - CORF - Partial Hospitalization - Other Health Care Professional Services - Clinical/Diagnostic Lab Services - Radiation Therapy Services - Cardiac Rehabilitation Services - Renal Dialysis - Outpatient Blood <p>All notes describe the in-network service unless they specifically mention the out-of-network service. Contact plan for details on the covered out of network service.</p>	<p>Care</p> <ul style="list-style-type: none"> - Outpatient Rehabilitation Services - Durable Medical Equipment - Prosthetic Devices - Diabetes Self-Monitoring Training and Supplies - Diagnostic Tests, X-Rays, and Lab Services - Bone Mass Measurement - Colorectal Screening Exam - Immunizations - Mammograms (Annual Screenings) - Pap Smears and Pelvic Exams - Prostate Cancer Screening Exams - Outpatient Prescription Drugs - Hearing Services - Vision Services - Routine Physical Exams - Health/Wellness Education - Transportation - CORF - Partial Hospitalization - Other Health Care Professional Services - Clinical/Diagnostic Lab Services - Radiation Therapy Services - Cardiac Rehabilitation Services - Renal Dialysis - Outpatient Blood <p>All notes describe the in-network service unless they specifically mention the out-of-network service. Contact plan for details on the covered out of</p>
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	<ul style="list-style-type: none"> - Podiatry Services - Outpatient Mental Health Care - Outpatient Substance Abuse Care - Outpatient Services/Surgery - Urgently Needed Care - Outpatient Rehabilitation Services - Durable Medical Equipment - Prosthetic Devices - Diabetes Self-Monitoring Training and Supplies - Diagnostic Tests, X-Rays, and Lab Services - Bone Mass Measurement - Colorectal Screening Exam - Immunizations - Mammograms (Annual Screenings) - Pap Smears and Pelvic Exams - Prostate Cancer Screening Exams - Outpatient Prescription Drugs - Hearing Services - Routine Physical Exams - CORF - Partial Hospitalization - Other Health Care Professional Services - Clinical/Diagnostic Lab Services - Radiation Therapy Services - Cardiac Rehabilitation Services - Renal Dialysis - Outpatient Blood <p>All notes describe the in-network service unless they</p>	<ul style="list-style-type: none"> - Outpatient Substance Abuse Care - Outpatient Services/Surgery - Durable Medical Equipment - Prosthetic Devices - Diabetes Self-Monitoring Training and Supplies - Diagnostic Tests, X-Rays, and Lab Services - Outpatient Prescription Drugs - CORF - Partial Hospitalization - Clinical/Diagnostic Lab Services - Radiation Therapy Services - Renal Dialysis - Outpatient Blood <p>All notes describe the in-network service unless they specifically mention the out-of-network service. Contact plan for details on the covered out of network service.</p>		network service.
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	specifically mention the out-of-network service. Contact plan for details on the covered out of network service.			
2 - Doctor and Hospital Choice (For more information, see Emergency - #15 and Urgently Needed Care - #16.)	You can go to doctors, specialists, and hospitals in or out of the network. Higher costs apply for out of network services. You do NOT need a referral to go to network doctors, specialists, and hospitals. You are covered for the following out of network services: - Inpatient Hospital Care - Inpatient Mental Health Care - Skilled Nursing Facility - Home Health Care - Doctor Office Visits - Chiropractic Services - Podiatry Services - Outpatient Mental Health Care - Outpatient Substance Abuse Care - Outpatient Services/Surgery - Ambulance Services - Urgently Needed Care - Outpatient Rehabilitation Services - Durable Medical Equipment - Prosthetic Devices - Diabetes Self-Monitoring Training and Supplies - Diagnostic Tests, X-Rays, and Lab Services - Bone Mass	You can go to doctors, specialists, and hospitals in or out of the network. Higher costs apply for out of network services. You do NOT need a referral to go to network doctors, specialists, and hospitals. You are covered for the following out of network services: - Inpatient Hospital Care - Inpatient Mental Health Care - Skilled Nursing Facility - Home Health Care - Doctor Office Visits - Chiropractic Services - Podiatry Services - Outpatient Mental Health Care - Outpatient Substance Abuse Care - Outpatient Services/Surgery - Ambulance Services - Urgently Needed Care - Outpatient Rehabilitation Services - Durable Medical Equipment - Prosthetic Devices - Diabetes Self-Monitoring Training and Supplies - Diagnostic Tests, X-Rays, and Lab Services - Bone Mass	You can go to doctors, specialists, and hospitals in or out of the network. Higher costs apply for out of network services. You do NOT need a referral to go to network doctors, specialists, and hospitals. You are covered for the following out of network services: - Inpatient Hospital Care - Inpatient Mental Health Care - Skilled Nursing Facility - Home Health Care - Doctor Office Visits - Chiropractic Services - Podiatry Services - Outpatient Mental Health Care - Outpatient Substance Abuse Care - Outpatient Services/Surgery - Ambulance Services - Urgently Needed Care - Outpatient Rehabilitation Services - Durable Medical Equipment - Prosthetic Devices - Diabetes Self-Monitoring Training and Supplies - Diagnostic Tests, X-Rays, and Lab Services - Bone Mass	You can go to doctors, specialists, and hospitals in or out of the network. Higher costs apply for out of network services. You do NOT need a referral to go to network doctors, specialists, and hospitals. You are covered for the following out of network services: - Inpatient Hospital Care - Inpatient Mental Health Care - Skilled Nursing Facility - Home Health Care - Doctor Office Visits - Chiropractic Services - Podiatry Services - Outpatient Mental Health Care - Outpatient Substance Abuse Care - Outpatient Services/Surgery - Ambulance Services - Urgently Needed Care - Outpatient Rehabilitation Services - Durable Medical Equipment - Prosthetic Devices - Diabetes Self-Monitoring Training and Supplies - Diagnostic Tests, X-Rays, and Lab Services - Bone Mass

	<p>Measurement</p> <ul style="list-style-type: none"> - Colorectal Screening Exam - Immunizations - Mammograms (Annual Screenings) - Pap Smears and Pelvic Exams - Prostate Cancer Screening Exams - Outpatient Prescription Drugs - Hearing Services - Vision Services - Routine Physical Exams - CORF - Partial Hospitalization - Other Health Care Professional Services - Clinical/Diagnostic Lab Services - Radiation Therapy Services - Cardiac Rehabilitation Services - Renal Dialysis - Outpatient Blood Authorization rules may apply for out of network services. Contact plan for details. You may pay a penalty for receiving out of network services without authorization from the plan for the following services. Contact plan for details. - Inpatient Hospital Care - Inpatient Mental Health Care - Skilled Nursing Facility - Home Health Care - Durable Medical Equipment - Prosthetic Devices - Diagnostic Tests, 	<p>Measurement</p> <ul style="list-style-type: none"> - Colorectal Screening Exam - Immunizations - Mammograms (Annual Screenings) - Pap Smears and Pelvic Exams - Prostate Cancer Screening Exams - Outpatient Prescription Drugs - Hearing Services - Vision Services - Routine Physical Exams - CORF - Partial Hospitalization - Other Health Care Professional Services - Clinical/Diagnostic Lab Services - Radiation Therapy Services - Cardiac Rehabilitation Services - Renal Dialysis - Outpatient Blood Authorization rules may apply for out of network services. Contact plan for details. You may pay a penalty for receiving out of network services without authorization from the plan for the following services. Contact plan for details. - Inpatient Hospital Care - Inpatient Mental Health Care - Skilled Nursing Facility - Home Health Care - Durable Medical Equipment - Prosthetic Devices - Diagnostic Tests, 	<p>Measurement</p> <ul style="list-style-type: none"> - Colorectal Screening Exam - Immunizations - Mammograms (Annual Screenings) - Pap Smears and Pelvic Exams - Prostate Cancer Screening Exams - Hearing Services - Vision Services - Routine Physical Exams - Health/Wellness Education - Transportation - CORF - Partial Hospitalization - Other Health Care Professional Services - Clinical/Diagnostic Lab Services - Radiation Therapy Services - Cardiac Rehabilitation Services - Renal Dialysis - Outpatient Blood Authorization rules may apply for out of network services. Contact plan for details. A separate doctor office visit copayment may apply for certain services. 	<p>Measurement</p> <ul style="list-style-type: none"> - Colorectal Screening Exam - Immunizations - Mammograms (Annual Screenings) - Pap Smears and Pelvic Exams - Prostate Cancer Screening Exams - Outpatient Prescription Drugs - Hearing Services - Vision Services - Routine Physical Exams - Health/Wellness Education - Transportation - CORF - Partial Hospitalization - Other Health Care Professional Services - Clinical/Diagnostic Lab Services - Radiation Therapy Services - Cardiac Rehabilitation Services - Renal Dialysis - Outpatient Blood Authorization rules may apply for out of network services. Contact plan for details. A separate doctor office visit copayment may apply for certain services.
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	<p>X-Rays, and Lab Services</p> <ul style="list-style-type: none"> - Partial Hospitalization - Clinical/Diagnostic Lab Services - Radiation Therapy Services <p>A separate doctor office visit copayment may apply for certain services.</p>	<p>X-Rays, and Lab Services</p> <ul style="list-style-type: none"> - Partial Hospitalization - Clinical/Diagnostic Lab Services - Radiation Therapy Services <p>A separate doctor office visit copayment may apply for certain services.</p>		
<p>3 - Inpatient Hospital Care (includes Substance Abuse and Rehabilitation Services)</p>	<p>You pay \$ 500 for each Medicare-covered stay at a network hospital. You pay: - 20 % of the cost each day for day(s) 1 and beyond for a stay at an out of network hospital. There is no copayment for additional days received at a network hospital. There is a \$ 1000 maximum out of pocket limit every year. You are covered for unlimited days each benefit period. Except in an emergency, you must get authorization from Excellus Health Plan, Inc. before you get this service. Failure to get authorization can result in significantly higher costs to you. Contact your plan for details.</p>	<p>You pay \$ 300 for each Medicare-covered stay at a network hospital. You pay: - 20 % of the cost each day for day(s) 1 and beyond for a stay at an out of network hospital. There is a \$ 600 maximum out of pocket limit every year. You are covered for unlimited days each benefit period. Except in an emergency, you must get authorization from Excellus Health Plan, Inc. before you get this service. Failure to get authorization can result in significantly higher costs to you. Contact your plan for details.</p>	<p>You pay \$ 100 for each Medicare-covered stay at a network hospital. You pay 20 % of the cost for each stay at an out of network hospital. There is no copayment for additional days received at a network hospital. You are covered for unlimited days each benefit period. Except in an emergency, you must get authorization from Traditional Blue Medicare PPO before you get this service. Failure to get authorization can result in significantly higher costs to you. Contact your plan for details.</p>	<p>You pay \$ 100 for each Medicare-covered stay at a network hospital. You pay 20 % of the cost for each stay at an out of network hospital. There is no copayment for additional days received at a network hospital. You are covered for unlimited days each benefit period. Except in an emergency, you must get authorization from Traditional Blue Medicare PPO before you get this service. Failure to get authorization can result in significantly higher costs to you. Contact your plan for details.</p>
<p>4 - Inpatient Mental Health Care</p>	<p>You pay \$ 500 for each Medicare-covered stay at a network hospital. You pay: - 20 % of the cost each day for day(s) 1 - 30 for</p>	<p>You pay \$ 300 for each Medicare-covered stay at a network hospital. You pay: - 20 % of the cost each day for day(s) 1 - 30 for</p>	<p>You pay \$ 100 for each Medicare-covered stay at a network hospital. You pay 20 % of the cost for each stay at an out of</p>	<p>You pay \$ 100 for each Medicare-covered stay at a network hospital. You pay 20 % of the cost for each stay at an out of</p>

	<p>a stay at an out of network hospital. The maximum out of pocket limit is covered under Inpatient Hospital Care. Medicare beneficiaries may only receive 190 days in a Psychiatric Hospital in a lifetime. Except in an emergency, you must get authorization from Excellus Health Plan, Inc. before you get this service. Failure to get authorization can result in significantly higher costs to you. Contact your plan for details.</p>	<p>a stay at an out of network hospital. The maximum out of pocket limit is covered under Inpatient Hospital Care. Medicare beneficiaries may only receive 190 days in a Psychiatric Hospital in a lifetime. Except in an emergency, you must get authorization from Excellus Health Plan, Inc. before you get this service. Failure to get authorization can result in significantly higher costs to you. Contact your plan for details.</p>	<p>network hospital. Medicare beneficiaries may only receive 190 days in a Psychiatric Hospital in a lifetime. Except in an emergency, you must get authorization from Traditional Blue Medicare PPO before you get this service. Failure to get authorization can result in significantly higher costs to you. Contact your plan for details.</p>	<p>network hospital. Medicare beneficiaries may only receive 190 days in a Psychiatric Hospital in a lifetime. Except in an emergency, you must get authorization from Traditional Blue Medicare PPO before you get this service. Failure to get authorization can result in significantly higher costs to you. Contact your plan for details.</p>
<p>5 - Skilled Nursing Facility (in a Medicare-certified skilled nursing facility)</p>	<p>You pay: - 10 % of the cost each day for day(s) 1 - 20 - 50 % of the cost each day for day(s) 21 - 100 for a Medicare-covered stay at a Skilled Nursing Facility. You pay 20 % of the cost for Medicare-covered services at an out of network Skilled Nursing Facility. 3-day prior hospital stay is required. You are covered for 100 days each benefit period. You must get authorization from Excellus Health Plan, Inc. before you get this service. Failure to get authorization can result in significantly higher costs to you. Contact your plan for details.</p>	<p>You pay: - 10 % of the cost each day for day(s) 1 - 20 - 50 % of the cost each day for day(s) 21 - 100 for a Medicare-covered stay at a Skilled Nursing Facility. You pay 20 % of the cost for Medicare-covered services at an out of network Skilled Nursing Facility. 3-day prior hospital stay is required. You are covered for 100 days each benefit period. You must get authorization from Excellus Health Plan, Inc. before you get this service. Failure to get authorization can result in significantly higher costs to you. Contact your plan for details.</p>	<p>You pay \$ 100 for each stay at a Skilled Nursing Facility. You pay 20 % of the cost for Medicare-covered services at an out of network Skilled Nursing Facility. No prior hospital stay is required. You are covered for 100 days each benefit period. You must get authorization from Traditional Blue Medicare PPO before you get this service. Failure to get authorization can result in significantly higher costs to you. Contact your plan for details.</p>	<p>You pay \$ 100 for each stay at a Skilled Nursing Facility. You pay 20 % of the cost for Medicare-covered services at an out of network Skilled Nursing Facility. No prior hospital stay is required. You are covered for 100 days each benefit period. You must get authorization from Traditional Blue Medicare PPO before you get this service. Failure to get authorization can result in significantly higher costs to you. Contact your plan for details.</p>

6 - Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	There is no copayment for Medicare-covered home health visits. You pay 20 % for out of network home health visits. You must get authorization from Excellus Health Plan, Inc. before you get this service. Failure to get authorization can result in significantly higher costs to you. Contact your plan for details.	There is no copayment for Medicare-covered home health visits. You pay 20 % for out of network home health visits. You must get authorization from Excellus Health Plan, Inc. before you get this service. Failure to get authorization can result in significantly higher costs to you. Contact your plan for details.	You pay \$ 15 for Medicare-covered home health visits. You pay \$ 20 for out of network home health visits. You must get authorization from Traditional Blue Medicare PPO before you get this service. Failure to get authorization can result in significantly higher costs to you. Contact your plan for details.	You pay \$ 15 for Medicare-covered home health visits. You pay \$ 20 for out of network home health visits. You must get authorization from Traditional Blue Medicare PPO before you get this service. Failure to get authorization can result in significantly higher costs to you. Contact your plan for details.
7 - Hospice	You must receive care from a Medicare-certified hospice.	You must receive care from a Medicare-certified hospice.	You must receive care from a Medicare-certified hospice.	You must receive care from a Medicare-certified hospice.
8 - Doctor Office Visits	You pay \$ 15 for each primary care doctor office visit for Medicare-covered services. You pay 20 % for each out of network primary care doctor office visit. You pay \$ 20 for each specialist visit for Medicare-covered services. You pay 20 % for each out of network specialist visit. See 32 - Routine Physical Exams for more information. If your coverage to Medicare Part B begins on or after January 1, 2005, you may receive a one time physical exam within the first six months of your new Part B coverage. This will not include laboratory tests. Please contact your plan for further	You pay \$ 5 for each primary care doctor office visit for Medicare-covered services. You pay \$ 25 for each out of network primary care doctor office visit. You pay \$ 15 for each specialist visit for Medicare-covered services. You pay \$ 25 for each out of network specialist visit. See 32 - Routine Physical Exams for more information. If your coverage to Medicare Part B begins on or after January 1, 2005, you may receive a one time physical exam within the first six months of your new Part B coverage. This will not include laboratory tests. Please contact your plan for further	You pay \$ 15 for each primary care doctor office visit for Medicare-covered services. You pay \$ 20 for each out of network primary care doctor office visit. You pay \$ 15 for each specialist visit for Medicare-covered services. You pay \$ 20 for each out of network specialist visit. See 32 - Routine Physical Exams for more information. If your coverage to Medicare Part B begins on or after January 1, 2005, you may receive a one time physical exam within the first six months of your new Part B coverage. This will not include laboratory tests. Please contact your plan for further	You pay \$ 15 for each primary care doctor office visit for Medicare-covered services. You pay \$ 20 for each out of network primary care doctor office visit. You pay \$ 15 for each specialist visit for Medicare-covered services. You pay \$ 20 for each out of network specialist visit. See 32 - Routine Physical Exams for more information. If your coverage to Medicare Part B begins on or after January 1, 2005, you may receive a one time physical exam within the first six months of your new Part B coverage. This will not include laboratory tests. Please contact your plan for further

	details.	details.	details.	details.
9 - Chiropractic Services	You pay \$ 20 for each Medicare-covered visit (manual manipulation of the spine to correct subluxation). You pay \$ 20 for out of network chiropractic services.	You pay \$ 15 for each Medicare-covered visit (manual manipulation of the spine to correct subluxation). You pay \$ 25 for out of network chiropractic services.	You pay \$ 15 for each Medicare-covered visit (manual manipulation of the spine to correct subluxation). You pay \$ 20 for out of network chiropractic services.	You pay \$ 15 for each Medicare-covered visit (manual manipulation of the spine to correct subluxation). You pay \$ 20 for out of network chiropractic services.
10 - Podiatry Services	You pay \$ 20 for each Medicare-covered visit (medically necessary foot care). You pay 20 % of the cost for out of network podiatry services.	You pay \$ 15 for each Medicare-covered visit (medically necessary foot care). You pay \$ 25 for out of network podiatry services.	You pay: - \$ 15 for each Medicare-covered visit (medically necessary foot care). - \$ 15 for each routine visit up to 3 visit(s) every year You pay \$ 20 for out of network podiatry services.	You pay: - \$ 15 for each Medicare-covered visit (medically necessary foot care). - \$ 15 for each routine visit up to 3 visit(s) every year You pay \$ 20 for out of network podiatry services.
11 - Outpatient Mental Health Care	For Medicare-covered Mental Health services, you pay \$ 20 for each individual/group therapy visit. You pay 20 % of the cost for out of network Mental Health services. You pay 20 % of the cost for out of network Mental Health services with a psychiatrist.	For Medicare-covered Mental Health services, you pay \$ 15 for each individual/group therapy visit. You pay 20 % of the cost for out of network Mental Health services. You pay 20 % of the cost for out of network Mental Health services with a psychiatrist.	For Medicare-covered Mental Health services, you pay 50 % of the cost for each individual/group therapy visit. You pay 20 % to 50 % of the cost for out of network Mental Health services. For Medicare-covered Mental Health services with a psychiatrist, you pay 20 % of the cost for each individual/group therapy visit. You pay 20 % to 50 % of the cost for out of network Mental Health services with a psychiatrist. You must get authorization from Traditional Blue Medicare PPO before you get this service. Failure to get authorization	For Medicare-covered Mental Health services, you pay 50 % of the cost for each individual/group therapy visit. You pay 20 % to 50 % of the cost for out of network Mental Health services. For Medicare-covered Mental Health services with a psychiatrist, you pay 20 % of the cost for each individual/group therapy visit. You pay 20 % to 50 % of the cost for out of network Mental Health services with a psychiatrist. You must get authorization from Traditional Blue Medicare PPO before you get this service. Failure to get authorization

			can result in significantly higher costs to you. Contact your plan for details.	can result in significantly higher costs to you. Contact your plan for details.
12 - Outpatient Substance Abuse Care	For Medicare-covered services, you pay \$ 20 for each individual/group visit. You pay 20 % of the cost for out of network outpatient substance abuse services.	For Medicare-covered services, you pay \$ 15 for each individual/group visit. You pay 20 % of the cost for out of network outpatient substance abuse services.	For Medicare-covered services, you pay 20 % of the cost for each individual/group visit. You pay 20 % of the cost for out of network outpatient substance abuse services.	For Medicare-covered services, you pay 20 % of the cost for each individual/group visit. You pay 20 % of the cost for out of network outpatient substance abuse services.
13 - Outpatient Services/Surgery	You pay \$ 100 for each Medicare-covered visit to an ambulatory surgical center. You pay \$ 0 to \$ 100 for each Medicare-covered visit to an outpatient hospital facility. You pay 20 % of the cost for services at an out of network ambulatory surgical center. You pay 20 % of the cost for services at an out of network outpatient hospital facility.	You pay \$ 35 for each Medicare-covered visit to an ambulatory surgical center. You pay \$ 15 to \$ 35 for each Medicare-covered visit to an outpatient hospital facility. You pay 20 % of the cost for services at an out of network ambulatory surgical center. You pay 20 % of the cost for services at an out of network outpatient hospital facility.	You pay \$ 15 for each Medicare-covered visit to an ambulatory surgical center. You pay \$ 15 for each Medicare-covered visit to an outpatient hospital facility. You pay \$ 20 for services at an out of network ambulatory surgical center. You pay \$ 20 for services at an out of network outpatient hospital facility. You must get authorization from Traditional Blue Medicare PPO before you get this service. Failure to get authorization can result in significantly higher costs to you. Contact your plan for details.	You pay \$ 15 for each Medicare-covered visit to an ambulatory surgical center. You pay \$ 15 for each Medicare-covered visit to an outpatient hospital facility. You pay \$ 20 for services at an out of network ambulatory surgical center. You pay \$ 20 for services at an out of network outpatient hospital facility. You must get authorization from Traditional Blue Medicare PPO before you get this service. Failure to get authorization can result in significantly higher costs to you. Contact your plan for details.
14 - Ambulance Services (medically necessary ambulance services)	You pay \$ 50 for Medicare-covered ambulance services. You pay \$ 50 for out of network ambulance services.	You pay \$ 50 for Medicare-covered ambulance services. You pay \$ 50 for out of network ambulance services.	You pay \$ 50 for Medicare-covered ambulance services.	You pay \$ 50 for Medicare-covered ambulance services.
15 - Emergency	You pay \$ 50 for	You pay \$ 50 for	You pay \$ 50 for	You pay \$ 50 for

Care (You may go to any emergency room if you reasonably believe you need emergency care.)	each Medicare-covered emergency room visit; you do not pay this amount if you are admitted to the hospital within 23 hour(s) for the same condition. Worldwide coverage.	each Medicare-covered emergency room visit; you do not pay this amount if you are admitted to the hospital within 23 hour(s) for the same condition. Worldwide coverage.	each Medicare-covered emergency room visit; you do not pay this amount if you are admitted to the hospital within 1 day for the same condition. Worldwide coverage.	each Medicare-covered emergency room visit; you do not pay this amount if you are admitted to the hospital within 1 day for the same condition. Worldwide coverage.
16 - Urgently Needed Care (This is NOT emergency care, and in most cases, is out of the service area.)	You pay \$ 20 for each Medicare-covered urgently needed care visit. You pay 20 % of the cost for out of network urgent care services. Worldwide coverage.	You pay \$ 15 for each Medicare-covered urgently needed care visit. You pay \$ 25 for out of network urgent care services. Worldwide coverage.	You pay \$ 50 for each Medicare-covered urgently needed care visit; you do not pay this amount if you are admitted to the hospital within 1 day for the same condition. Worldwide coverage.	You pay \$ 50 for each Medicare-covered urgently needed care visit; you do not pay this amount if you are admitted to the hospital within 1 day for the same condition. Worldwide coverage.
17 - Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	You pay \$ 20 for each Medicare-covered Occupational Therapy visit. You pay \$ 20 for each Medicare-covered Physical Therapy and/or Speech/Language Therapy visit. You pay 20 % of the cost for out of network Occupational Therapy services. You pay 20 % of the cost for out of network Physical Therapy and/or Speech language therapy services.	You pay \$ 15 for each Medicare-covered Occupational Therapy visit. You pay \$ 15 for each Medicare-covered Physical Therapy and/or Speech/Language Therapy visit. You pay \$ 25 for out of network Occupational Therapy services. You pay \$ 25 for out of network Physical Therapy and/or Speech language therapy services.	You pay \$ 15 for each Medicare-covered Occupational Therapy visit. You pay \$ 15 for each Medicare-covered Physical Therapy and/or Speech/Language Therapy visit. You pay \$ 20 for out of network Occupational Therapy services. You pay \$ 20 for out of network Physical Therapy and/or Speech language therapy services.	You pay \$ 15 for each Medicare-covered Occupational Therapy visit. You pay \$ 15 for each Medicare-covered Physical Therapy and/or Speech/Language Therapy visit. You pay \$ 20 for out of network Occupational Therapy services. You pay \$ 20 for out of network Physical Therapy and/or Speech language therapy services.
18 - Durable Medical Equipment (includes wheelchairs, oxygen, etc.)	You pay 20 % of the cost for each Medicare-covered item. You pay 20 % of the cost for durable medical equipment purchased out of network. You must	You pay 20 % of the cost for each Medicare-covered item. You pay 20 % of the cost for durable medical equipment purchased out of network. You must	You pay 30 % of the cost for each Medicare-covered item. You pay 50 % of the cost for durable medical equipment purchased out of network. You must	You pay 30 % of the cost for each Medicare-covered item. You pay 50 % of the cost for durable medical equipment purchased out of network. You must

	get authorization from Excellus Health Plan, Inc. before you get this service. Failure to get authorization can result in significantly higher costs to you. Contact your plan for details.	get authorization from Excellus Health Plan, Inc. before you get this service. Failure to get authorization can result in significantly higher costs to you. Contact your plan for details.	get authorization from Traditional Blue Medicare PPO before you get this service. Failure to get authorization can result in significantly higher costs to you. Contact your plan for details.	get authorization from Traditional Blue Medicare PPO before you get this service. Failure to get authorization can result in significantly higher costs to you. Contact your plan for details.
19 - Prosthetic Devices (includes braces, artificial limbs and eyes, etc.)	You pay 20 % of the cost for each Medicare-covered item. You pay 20 % of the cost for prosthetic devices purchased out of network.	You pay 20 % of the cost for each Medicare-covered item. You pay 20 % of the cost for prosthetic devices purchased out of network.	You pay 20 % of the cost for each Medicare-covered item. You pay 20 % of the cost for prosthetic devices purchased out of network.	You pay 20 % of the cost for each Medicare-covered item. You pay 20 % of the cost for prosthetic devices purchased out of network.
20 - Diabetes Self-Monitoring Training and Supplies (includes coverage for glucose monitors, test strips, lancets, and self-management training)	There is no copayment for Diabetes self-monitoring training. You pay 20 % of the cost for out of network Diabetes self-monitoring training. You pay \$ 20 for each Medicare-covered Diabetes Supply item. You pay 20 % of the cost for each Diabetes Supply item purchased out of network.	There is no copayment for Diabetes self-monitoring training. You pay \$ 25 for out of network Diabetes self-monitoring training. You pay \$ 15 for each Medicare-covered Diabetes Supply item. You pay 20 % of the cost for each Diabetes Supply item purchased out of network.	You pay \$ 15 for Medicare-covered Diabetes self-monitoring training. You pay \$ 20 for out of network Diabetes self-monitoring training. You pay 20 % of the cost for each Medicare-covered Diabetes Supply item. You pay 20 % of the cost for each Diabetes Supply item purchased out of network.	You pay \$ 15 for Medicare-covered Diabetes self-monitoring training. You pay \$ 20 for out of network Diabetes self-monitoring training. You pay 20 % of the cost for each Medicare-covered Diabetes Supply item. You pay 20 % of the cost for each Diabetes Supply item purchased out of network.
21 - Diagnostic Tests, X-Rays, and Lab Services	You pay: - \$ 0 for each Medicare-covered clinical/diagnostic lab service. - \$ 20 for each Medicare-covered radiation therapy service. - \$ 20 for each Medicare-covered X-ray visit. You pay: - 20 % of the cost for each out of network clinical/diagnostic lab service - 20 % of the cost for each	You pay: - \$ 0 for each Medicare-covered clinical/diagnostic lab service. - \$ 15 for each Medicare-covered radiation therapy service. - \$ 15 for each Medicare-covered X-ray visit. You pay: - 20 % of the cost for each out of network clinical/diagnostic lab service - 20 % of the cost for each	You pay: - \$ 15 for each Medicare-covered clinical/diagnostic lab service. - \$ 15 for each Medicare-covered radiation therapy service. - \$ 15 for each Medicare-covered X-ray visit. You pay: - \$ 20 for each out of network clinical/diagnostic lab service - \$ 20 for each out of network radiation	You pay: - \$ 15 for each Medicare-covered clinical/diagnostic lab service. - \$ 15 for each Medicare-covered radiation therapy service. - \$ 15 for each Medicare-covered X-ray visit. You pay: - \$ 20 for each out of network clinical/diagnostic lab service - \$ 20 for each out of network radiation

	out of network radiation therapy service. - 20 % of the cost for out of network X-ray services	out of network radiation therapy service. - 20 % of the cost for out of network X-ray services	therapy service. - \$ 20 for out of network X-ray services	therapy service. - \$ 20 for out of network X-ray services
Preventive Services				
22 - Bone Mass Measurement (for people with Medicare who are at risk)	There is no copayment for each Medicare-covered Bone Mass Measurement. You pay 20 % of the cost for each out of network Bone Mass measurement.	There is no copayment for each Medicare-covered Bone Mass Measurement. You pay \$ 25 for each out of network Bone Mass measurement.	There is no copayment for each Medicare-covered Bone Mass Measurement. You pay \$ 20 for each out of network Bone Mass measurement.	There is no copayment for each Medicare-covered Bone Mass Measurement. You pay \$ 20 for each out of network Bone Mass measurement.
23 - Colorectal Screening Exams (for people with Medicare age 50 and older)	There is no copayment for Medicare-covered Colorectal Screening Exams. You pay 20 % of the cost for each out of network Colorectal Screening exam.	There is no copayment for Medicare-covered Colorectal Screening Exams. You pay \$ 25 for each out of network Colorectal Screening exam.	There is no copayment for Medicare-covered Colorectal Screening Exams. You pay \$ 20 for each out of network Colorectal Screening exam.	There is no copayment for Medicare-covered Colorectal Screening Exams. You pay \$ 20 for each out of network Colorectal Screening exam.
24 - Immunizations (Flu vaccine, Hepatitis B vaccine - for people with Medicare who are at risk, Pneumonia vaccine)	There is no copayment for the Pneumonia and Flu vaccines. No referral necessary for Medicare-covered influenza and pneumococcal vaccines No referral necessary for other immunizations. There is no copayment for the Hepatitis B vaccine. You pay 20 % of the cost for each out of network Immunization.	There is no copayment for the Pneumonia and Flu vaccines. No referral necessary for Medicare-covered influenza and pneumococcal vaccines There is no copayment for the Hepatitis B vaccine. You pay \$ 25 for each out of network Immunization.	There is no copayment for the Pneumonia and Flu vaccines. No referral necessary for Medicare-covered influenza and pneumococcal vaccines There is no copayment for the Hepatitis B vaccine. You pay \$ 20 for each out of network Immunization.	There is no copayment for the Pneumonia and Flu vaccines. No referral necessary for Medicare-covered influenza and pneumococcal vaccines There is no copayment for the Hepatitis B vaccine. You pay \$ 20 for each out of network Immunization.
25 - Mammograms (Annual Screening) (for women with Medicare age 40)	There is no copayment for Medicare-covered Screening Mammograms. You pay 20 % of the	There is no copayment for Medicare-covered Screening Mammograms. You pay \$ 25 for each	There is no copayment for Medicare-covered Screening Mammograms. You pay \$ 20 for each	There is no copayment for Medicare-covered Screening Mammograms. You pay \$ 20 for each

and older)	cost for each out of network Screening Mammogram. No referral necessary for Medicare-covered screenings.	out of network Screening Mammogram. No referral necessary for Medicare-covered screenings.	out of network Screening Mammogram. No referral necessary for Medicare-covered screenings.	out of network Screening Mammogram. No referral necessary for Medicare-covered screenings.
26 - Pap Smears and Pelvic Exams (for women with Medicare)	There is no copayment for Medicare-covered Pap Smears and Pelvic Exams. You pay 20 % of the cost for each out of network Pap Smear and Pelvic Exam.	There is no copayment for Medicare-covered Pap Smears and Pelvic Exams. You pay \$ 25 for each out of network Pap Smear and Pelvic Exam.	You pay: - \$ 0 for each Medicare-covered Pap Smear - \$ 15 for each additional Pap Smear up to 1 Pap Smear(s) every year - \$ 15 for each Medicare-covered Pelvic Exam You pay \$ 20 for each out of network Pap Smear and Pelvic Exam.	You pay: - \$ 0 for each Medicare-covered Pap Smear - \$ 15 for each additional Pap Smear up to 1 Pap Smear(s) every year - \$ 15 for each Medicare-covered Pelvic Exam You pay \$ 20 for each out of network Pap Smear and Pelvic Exam.
27 - Prostate Cancer Screening Exams (for men with Medicare age 50 and older)	There is no copayment for Medicare-covered Prostate Cancer Screening exams. You pay 20 % of the cost for each out of network Prostate Screening Exam.	There is no copayment for Medicare-covered Prostate Cancer Screening exams. You pay \$ 25 for each out of network Prostate Screening Exam.	There is no copayment for Medicare-covered Prostate Cancer Screening exams. You pay \$ 20 for each out of network Prostate Screening Exam.	There is no copayment for Medicare-covered Prostate Cancer Screening exams. You pay \$ 20 for each out of network Prostate Screening Exam.
Additional Benefits (What Original Medicare Does NOT Cover)				
28 - Outpatient Prescription Drugs	For prescription drugs, you pay for each prescription or refill: - \$ 10 for Generic drugs up to a 30-day supply - \$ 30 for mail order Generic drugs up to a 90-day supply There is no individual limit on Generic drugs. You must use designated retail pharmacies, managed care-owned pharmacies, and mail order to get your prescription drugs.	You pay 100% for most prescription drugs.	You pay 100% for most prescription drugs.	For prescription drugs, you pay for each prescription or refill: - \$ 7 for Formulary Generic drugs up to a 30-day supply - \$ 25 for Formulary Brand drugs up to a 30-day supply - \$ 7 for mail order Formulary Generic drugs up to a 30-day supply - \$ 25 for mail order Formulary Brand drugs up to a 30-day supply There is no individual limit on Formulary Generic drugs. There is a \$

				<p>125 limit quarterly for Formulary Brand drugs. Any unused amounts can be carried forward to the next period within the contract period. Drugs that are covered by Original Medicare do not count toward your prescription drug limit. Plans can calculate the part you pay in different ways. The copayment does not apply toward the plan prescription limit. Please ask Traditional Blue Medicare PPO about how we determine drug costs that count towards these limits. You must use designated retail pharmacies and mail order to get your prescription drugs. Authorization may be required for prescription drugs.</p>
29 - Dental Services	In general, you pay 100% for dental services.	In general, you pay 100% for dental services.	In general, you pay 100% for dental services.	In general, you pay 100% for dental services.
30 - Hearing Services	<p>You pay: - \$ 20 for each Medicare-covered hearing exam (diagnostic hearing exams). - \$ 20 for each routine hearing test You pay 20 % of the cost for out of network hearing exams. - 100 % of the cost for each hearing aid up to 1 aid(s) every three years You are covered up to \$ 300</p>	<p>You pay: - \$ 15 for each Medicare-covered hearing exam (diagnostic hearing exams). - \$ 15 for each routine hearing test You pay \$ 25 for out of network hearing exams. - 100 % of the cost for each hearing aid up to 1 aid(s) every three years You are covered up to \$ 300 for hearing aids</p>	<p>In general, you pay 100% for routine hearing exams and hearing aids. You pay: - \$ 15 for each Medicare-covered hearing exam (diagnostic hearing exams). You pay \$ 20 for out of network hearing exams.</p>	<p>In general, you pay 100% for routine hearing exams and hearing aids. You pay: - \$ 15 for each Medicare-covered hearing exam (diagnostic hearing exams). You pay \$ 20 for out of network hearing exams.</p>

	for hearing aids every three years.	every three years.		
31 - Vision Services	You pay: - \$ 20 for Medicare-covered eye wear (one pair of eyeglasses or contact lenses after each cataract surgery) - \$ 20 for each Medicare-covered eye exam (diagnosis and treatment for diseases and conditions of the eye) - \$ 20 for each Routine eye exam, limited to 1 exam(s) every year You pay \$ 20 for out of network eye exams. - 100 % of the cost for glasses - 100 % of the cost for contacts. You are covered up to \$ 60 for eye wear every year.	You pay: - \$ 15 for Medicare-covered eye wear (one pair of eyeglasses or contact lenses after each cataract surgery) - \$ 15 for each Medicare-covered eye exam (diagnosis and treatment for diseases and conditions of the eye) - \$ 15 for each Routine eye exam, limited to 1 exam(s) every year You pay \$ 25 for out of network eye exams. - 100 % of the cost for glasses - 100 % of the cost for contacts. You are covered up to \$ 60 for eye wear every year.	There is no copayment for the following items: - Medicare-covered eye wear (one pair of eyeglasses or contact lenses after each cataract surgery) You pay: - \$ 15 for each Medicare-covered eye exam (diagnosis and treatment for diseases and conditions of the eye) - \$ 15 for each Routine eye exam, limited to 1 exam(s) every year You pay \$ 20 for out of network eye exams. You pay \$ 20 for out of network eye wear.	There is no copayment for the following items: - Medicare-covered eye wear (one pair of eyeglasses or contact lenses after each cataract surgery) You pay: - \$ 15 for each Medicare-covered eye exam (diagnosis and treatment for diseases and conditions of the eye) - \$ 15 for each Routine eye exam, limited to 1 exam(s) every year You pay \$ 20 for out of network eye exams. You pay \$ 20 for out of network eye wear.
32 - Routine Physical Exams	You pay \$ 15 for each exam. You pay 20 % of the cost for each out of network routine physical exam. You are covered for an unlimited number of exams.	You pay \$ 5 for each exam. You pay \$ 25 for each out of network routine physical exam. You are covered for an unlimited number of exams.	There is no copayment for routine physical exams. You pay \$ 20 for each out of network routine physical exam. You are covered up to 1 exam(s) every year.	There is no copayment for routine physical exams. You pay \$ 20 for each out of network routine physical exam. You are covered up to 1 exam(s) every year.
Health/Wellness Education	You are covered for the following: - Newsletter - Nutritional Training - Congestive Heart Program - Health Club Membership/Fitness Classes - Nursing Hotline - Disease Management - Other Wellness Services	You are covered for the following: - Newsletter - Nutritional Training - Congestive Heart Program - Health Club Membership/Fitness Classes - Nursing Hotline - Disease Management - Other Wellness Services	You are covered for the following: - Health Ed Classes - Newsletter - Nutritional Training - Smoking Cessation - Congestive Heart Program - Health Club Membership/Fitness Classes - Nursing Hotline - Disease Management	You are covered for the following: - Health Ed Classes - Newsletter - Nutritional Training - Smoking Cessation - Congestive Heart Program - Health Club Membership/Fitness Classes - Nursing Hotline - Disease Management
Transportation (Routine)			You pay \$ 15 for each round trip to	You pay \$ 15 for each round trip to

			Plan-approved location. You pay \$ 20 for out of network transportation services.	Plan-approved location. You pay \$ 20 for out of network transportation services.
Acupuncture				
Point of Service				
Optional Benefits				
Optional Supplemental Benefits	This plan does not offer any optional supplemental benefit packages.	This plan does not offer any optional supplemental benefit packages.	This plan does not offer any optional supplemental benefit packages.	This plan does not offer any optional supplemental benefit packages.